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Changes in the Delivery of Selected
Mental Health Services at Veterans
Administration Medical Centers

Statement of
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SUMMARY

In 1985, the Veterans Administration (VA) implemented a new resource allocation methodology that is designed to encourage increased productivity and efficiency at its medical centers. Through a survey of 14 medical centers, GAO found that, in response to the methodology's incentives, changes were being made in the treatment programs for veterans with post-traumatic stress disorders, alcohol and drug dependencies, and other long-term psychiatric conditions.

Most of the changes GAO identified were rewarded under the methodology. However, some changes, primarily those aimed at shortening the lengths of stay in programs treating post-traumatic stress disorders, penalized, rather than rewarded, the centers' programs. VA is currently analyzing how the methodology relates to psychiatric programs.

According to VA officials, some service delivery changes made in response to the methodology were viewed as beneficial to veterans because they increased access to care, while others were perceived less favorably because they limited the care provided. However, VA has not conducted local or national clinical evaluations to determine the effects of the changes on the quality of care delivered to veterans.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the preliminary results of our work at several Veterans Administration (VA) medical centers on inpatient programs providing treatment of veterans with post-traumatic stress disorders (PTSD), alcohol and drug dependencies, and other long-term psychiatric disorders. As you know, in fiscal year 1985, VA introduced a new budget allocation system called the resource allocation methodology, which is intended to encourage increased productivity and efficiency at its medical centers. We visited 3 medical centers to identify changes they made in the three programs in response to the new methodology and phoned officials at 11 other centers to discuss whether they had also made changes.

Medical center officials had made changes in one or more of the programs at the centers we contacted, and these officials said that most of the changes were made in response to the incentives VA had incorporated into the methodology. Several types of changes resulted in the programs' benefiting under the methodology. However, when centers attempted to reduce their lengths of stay in some programs, primarily PTSD, these programs were, in effect, penalized rather than rewarded. We believe this occurred because the current methodology is not adequate to measure productivity increases for programs like PTSD, which require long patient stays. VA is currently analyzing how the methodology relates to psychiatric programs.

Medical center officials provided us their views concerning how the changes made in the programs affected the care provided to veterans. However, VA has not conducted local or national clinical evaluations to determine the effects of the changes on the quality of care provided to the veterans served.

CHANGES REWARDED UNDER THE METHODOLOGY

I would first like to highlight five types of changes at the 14 medical centers that were rewarded under the methodology.

Length of Stay

Under the methodology, workload is measured through the use of diagnosis related groups (DRGs)--a method used to classify patients with similar diagnoses and other characteristics. Patients in each group generally are expected to have comparable costs of treatment based on similar lengths of stay. A basic credit is earned for each patient discharged under each DRG regardless of the patient's length of stay, up to a specified limit. For example, in fiscal year 1986 an alcohol treatment program earned \$1,550 for certain discharges within a 40-day limit; PTSD programs earned \$1,772 for each patient discharged within a 45-day limit. As long as patient stays already are below the limit, programs would benefit if they were able to discharge patients more rapidly and thereby treat additional patients within existing staffing and other resource constraints.

Two medical centers we visited, as well as five contacted by phone, earned additional workload credits because they reduced lengths of stay. For example, one alcohol and drug treatment program we visited earned \$1,550 in 4 weeks rather than 5 by reducing the predefined length of stay 1 week. According to program officials, the shortened length of stay was expected to have varying effects on veterans depending on their conditions. However, they argued that the change would provide greater access to care by allowing more veterans to be served each year.

At a second center we visited, the predefined length of stay was reduced from 4 to 2 weeks for an alcohol treatment program. This allowed the program to earn \$3,110 from serving two patients in the same time period that it had previously needed to earn \$1,550 from serving one. However, shortening the program's length of stay led to a change in the patient population served, according to program officials. Before the change, the program served patients with alcohol dependence problems that were exacerbated by the presence of other medical and psychological problems. Because officials felt that these patients could not be treated in the 2-week period, new admissions to the program were restricted to patients with fewer complicating problems.

New Program Components

Two medical centers we visited, as well as three contacted by phone, added new program components, which allowed them to earn additional credits. Officials told us that these changes were made to improve service delivery to veterans.

For example, one medical center we visited and two we contacted by phone implemented new assessment programs for PTSD patients without additional costs because the programs were implemented with existing staff. The assessment programs, which were designed for patients to have a 3-day length of stay, earned \$1,772 for each patient diagnosed to have PTSD. Before this change, the program received no credit for patients' assessments because they were performed elsewhere. According to VA officials at the center we visited, the new 3-day program was developed to provide a more comprehensive assessment of patients seeking treatment than was done previously. Also, it allowed the veterans to make more informed decisions about whether they wished to participate in the center's regular treatment program.

One alcohol treatment program we visited introduced a new program component that allowed discharged patients to return for a 3-day stay to reinforce the results of prior treatment efforts. The program earned a credit of \$1,550 for each 3-day stay.

Improved Bed Utilization

Officials at one medical center we visited improved its bed utilization by shifting beds from general psychiatry to the PTSD program in response to the methodology's financial incentives. The beds would have remained idle for an extended time in the psychiatry unit because of difficulties in hiring nurses and other medical staff. According to VA officials, the PTSD program was operating at full capacity, and its existing staffing level was sufficient to cover the additional beds. Thus, new patients were treated for whom workload credits were earned that would otherwise not have been earned.

Administrative Changes

Two medical centers we visited made administrative changes, which program officials told us they made to improve the accuracy of the data being reported. For example, one center reevaluated the diagnoses of patients discharged from its 3-day assessment program. It decided that another psychiatric diagnosis was more clinically appropriate than PTSD for at least 60 percent of the patients. By changing these patients' diagnoses, the program earned additional credit because the basic credit for each discharge with the other diagnosis is \$2,436 while the basic credit for each discharge with a PTSD diagnosis is \$1,772. While this change increased the program's earned credits, it was not expected to affect the veterans served.

Staffing Changes

One of the ways that programs can achieve the methodology's objectives to increase efficiency is to reduce costs. Staffing costs accounted for more than 90 percent of the direct costs for treating psychiatry patients at the medical centers we visited. Staff reductions, therefore, represent the primary means for a program's costs to be reduced.

Officials at two centers we visited and six contacted by phone told us that staffing levels were reduced. In two PTSD programs we visited, for example, staffing levels were reduced about 15 percent--3.5 full-time employee equivalents in one program and 4 in the other. Program officials reported that all of the staff reductions, which involved social workers, nurses, and other direct care providers, were accomplished through attrition or transfers to other sections of the medical centers. They also reported that the reductions were generally expected to reduce the care provided to veterans but that the care provided would remain at acceptable levels of quality.

CHANGES THAT PENALIZED PROGRAMS

Changes made to shorten lengths of stay penalize certain programs. Programs earn the same credit for each patient discharged within a DRG's established length of stay limit. However, for discharged patients with lengths of stay beyond the established limit for a DRG, programs earn a basic credit for the

DRG plus additional credits equivalent to \$90 a day for each day of care over the established limit.

At the facilities we visited, three PTSD programs, one alcohol and drug program, and one long-term psychiatry program reduced their lengths of stay and received lower, rather than higher, credits under the methodology. We believe that this occurred primarily because the treatment in these five programs always took much longer than the length of stay limit established for the DRG covering such patients. The following example illustrates this situation.

A PTSD program we visited reduced its predefined length of stay from 120 to 90 days. Before the change the program earned \$8,522 for a 120-day stay. After the 30-day reduction, the program earned \$5,822 for each patient discharged--a \$2,700 loss. The change gained the facility 30 days during which new patients were treated. However, the program earned only \$1,772 for the first 45 days of each new patient's stay.

We found that similar results occurred in 7 of the 11 PTSD programs and 4 of the 9 long-term psychiatry programs at the centers we phoned. Officials at all but one of the centers told us that these changes were made in response to the introduction of the resource allocation methodology even though our analysis suggests they reduced the aggregate credit the programs could earn.

RECENT REFINEMENTS IN THE METHODOLOGY

Mr. Chairman, it is important to note that VA's Department of Medicine and Surgery continues to analyze the methodology as it relates to psychiatry. In 1984 VA began a project to identify more clinically meaningful psychiatric DRGs. The results of this analysis are being reviewed by VA officials and outside experts.

Also, VA has recently changed the implementation of the methodology to recategorize its medical centers into six groups of similar sizes and types of facilities. One of the groups contains medical centers designated primarily as psychiatric facilities. This change--which will affect budget allocations for fiscal year 1989--is intended to enable medical centers to compete for budget resources under the methodology with similar facilities rather than with all medical centers in the system. It is not yet clear whether this regrouping of facilities will help to alleviate the impact of the penalties that some programs incur when they reduce lengths of stay.

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This completes my prepared statement, Mr. Chairman. My colleagues and I would be pleased to respond to your questions.